Cancer Insurance

Claim Notification Form

Need any help completing this form? **1300 880 750** 8am-8pm

INSURANCELINE

1. Policy Owner (Patient):
2. Policy Number: ☐☐☐☐☐☐☐☐☐
3. Life Insured to complete: PART A, PART B, PART D (DECLARATION) and MEDICARE AUTHORITY Form as attached.
4. Policy Owner (Patient) to complete: PART C
5. Treating Specialist to complete: PART E (SPECIALIST'S MEDICAL REPORT)
   (Any fees for the completion of the Specialist's Medical Report is the responsibility of the Patient)

PART A – PERSONAL DETAILS OF THE LIFE INSURED

Surname: First name:

Date of Birth: dd: mm: yyyy:

Height: Weight:

Occupation:

Current Residential Address:

suburb: state: postcode:

Postal Address:

Email Address:

Phone Numbers: (H) (W) (Mob)

PART B – MEDICAL DETAILS OF THE LIFE INSURED

1. What diagnosis have you been given for your condition?
2. When were you diagnosed?
3. What are/were your symptoms as a result of this condition?
4. On what date did your symptoms first commence?
5. On what date did you first attend a doctor as a result of these symptoms?
6. Have you previously had the same or similar condition or symptoms? No ○ Yes ○

   If "yes", please provide full details:

PART B – MEDICAL DETAILS OF THE LIFE INSURED CONTINUED

7. Please provide contact details for the following:

The doctor who provided your diagnosis:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

The first medical practitioner you saw for this condition:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

How long have you known this doctor? (If less than 12 months, please provide the name and address of your previous doctor).

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

The doctor from whom you are currently receiving medical treatment:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

The details of any other Specialists/Doctors you may have seen or are continuing to see for this condition:

Name:

Address:

Phone Number: Date last seen: dd: mm: yyyy:

8. What treatment/s are you currently receiving and how frequently?

9. If you have Private Medical Insurance, please provide the following details:

Fund Name:

Membership Number:

10. Have you made, or do you intend to make, a claim with any insurer? No ○ Yes ○

11. Do you have any additional information you would like to advise concerning your claim?

It is essential you provide to TAL copies of all test results confirming your diagnosis. Should the test results not be provided with this claim form it may result in delays to the assessment of your claim.

PART C – POLICY DISCHARGE TO BE COMPLETED BY THE POLICY OWNER

(Please note this section of the form will only be used if TAL accepts liability for the claim)

I / We hereby request payment of the benefit amount payable for the above policy to be paid by cheque or direct credit made payable to:

(Payee) of

Address

I / We accept payment in full satisfaction of all Cancer Insurance claims whatsoever under the above policy for the above life insured and do hereby discharge TAL Life Limited from all liability thereunder other than for payment of the amount stated.

Sign here: Date: dd / mm / yy

Please print name:

PART D – DECLARATION TO BE COMPLETED BY THE LIFE INSURED

I, (full name) (PRINT NAME) declare that the answers and statements made in this form are true and complete in every particular to the best of my knowledge.

I consent to TAL Life Limited seeking and obtaining information from any other person or company in respect of this claim. I authorise and request any doctor who has been, or may be, consulted by me to divulge at any time to TAL, or any legal tribunal any information that may have been acquired with regard to myself.

Sign here: Date: dd / mm / yy

Please print name:

YOUR PRIVACY

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The way in which InsuranceLine collects, uses, secures and discloses your personal information is set out in the InsuranceLine Privacy Policy available at www.insuranceline.com.au/Privacy-Policy or free of charge on request to InsuranceLine by contacting 1300 880 750 or questions@insuranceline.com.au

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PART E – SPECIALIST'S MEDICAL REPORT TO BE COMPLETED BY THE LIFE INSURED'S TREATING SPECIALIST

(Any costs incurred in the completion of this report are to be paid by the Patient).

Life Insured Surname: First name:

Date of Birth: dd: mm: yyyy:

1. When was the Patient first referred to you and by whom?

2. For what condition were they referred to you?

3. What is your diagnosis of the Patient's current condition?

4. On what date was this diagnosis made?

5. When did the Patient first experience these symptoms?

6. What were these symptoms?

7. Has the Patient previously suffered from the same or a related condition? No ☐ Yes ☐

   If "YES", please provide details:

8. On the basis of which objective tests/investigations was this diagnosis based?

9. Has the Patient been hospitalised or consulted any other medical practitioner/s in relation to this condition? No ☐ Yes ☐

   If "YES", please provide details:

10. Is there any relevant family history? No ☐ Yes ☐

    If "YES", please provide details:

11. Has the Patient ever been a smoker? No ☐ Yes ☐

    If "YES", please provide dates and daily usage.

It is essential you provide to TAL copies of all test results confirming the diagnosis (eg, histopathology, ECG results, etc)

The policy defines the Insured Conditions as set out below.

	Cancer means...
Explanation	The presence of one or more malignant tumours.
Evidence Required	This requires the malignant tumour to be characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. *Carcinoma in situ of the breast is covered if it results directly in the removal of the entire breast. The procedure must be performed specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment.
Conditions Not Covered	The following tumours are excluded: • Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant*; • All skin cancers, unless there is evidence of metastases; • Melanoma of the skin at Stage 1A (tumour thickness of less than or equal to 1.00mm, Clark level II or III, without ulceration); • Prostatic cancers which are histologically described as TNM Classification T1 or are of another equivalent or lesser classification, unless resulting in the surgical removal of the prostate; • Papillary Micro-Carcinoma of the Thyroid or Bladder; and • Chronic Lymphocytic Leukaemia less than Rai Stage 1.

12. In your opinion, does the Patient's condition fully satisfy the definition of the event? No ☐ Yes ☐

Please comment:

SPECIALIST DETAILS:

Name:

Qualifications:

Address:

Phone Number: Fax Number:

Sign here: Date: dd / mm / yy

THANK YOU FOR YOUR ASSISTANCE

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